PEER EDUCATION SYSTEM

IN HIV/AIDS PROGRAMS

.... A UNIQUE EXPERIENCE

DR. RAVI RAJ WILLIAM

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FOREWORD

HIV/AIDS prevention and care of the infected have become critical issues in many developing countries. It is estimated that India now, has 3.9 million people living with HIV/AIDS.

Sexual transmission accounts for more than 85% of the spread of HIV infection. It is necessary that people with high-risk behaviour are informed about appropriate preventive strategies and services so that they can protect themselves from contracting the disease.

Global experience has shown that the Peer Education System is the best channel of communication by which sensitive messages could be passed on to the vulnerable population, who are the potential victims of the epidemic.

I congratulate Dr.Ravi Raj William who has a very rich experience in dealing with the HIV/AIDS scenario of India, for documenting his experiences and contributing towards the clarity & further development of the Peer Education System.

The process of the Peer Education System documented in this manual, will be of immense guidance and help to the program trainers and managers, who are implementing targeted AIDS preventive-intervention programs and the care & support programs of the HIV infected people.

I hope and wish that this manual brings about greater changes in the projects, by implementing efficient and effective targeted AIDS preventive-intervention programs as well as care & support programs.

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FROM THE AUTHOR'S DESK

It is my pleasure and privilege to reach the dedicated personnel who are working in the field of HIV/AIDS Prevention and Care & Support of infected. This time I have takenup the critical but important & challenging issue "Peer Education System" and sharing my experiences. Most of the experiences shared are the outcome of working closely with AIDS Prevention and Control (APAC) project, the USAID/NACO Network, Tamilnadu and CORDAID's network.

The thematic intervention projects are implemented for high-risk behavioural groups. This target community is usually outside the range and reach of the typical institutions of social change and welfare. Naturally, Public Health personnel, social scientists and technicians have difficulties in effectively reaching this audience. The only way of reaching this audience is through Peer Educators (PEs) who are a part and parcel of this vulnerable group and they could communicate effectively with a fellow Female Sex Worker/ fellow Men having sex with men and for that matter even with their clients. In the process, one could see the amalgamation of the two experiences, the experience of a PE and that of a Peer. The PEs become the nuclei of the whole range of activities in HIV/AIDS Prevention and Care & Support. Moreover, the sustainability of the initiated activities depend on this core group. In this manual, the whole proxis, the dynamics, capacity building, continuously handholding, information gathering & sharing and graduating PEs are dealt with in details towards clarity.

In the process of learning and bringingout this manual, the role of Dr.Bimal Charles, the Project Director of APAC is immensely admirable. He has not only inspired me but also contributed greatly to this work. I register my thanks and acknowledgement to him. Mr.J.Benjamin Franklin, the senior social scientist has encouraged me in this work and has contributed to the learning and I thank him. Dr. Madhavan Nayar, senior consultant APAC has been a source of inspiration and I am thankful to him. My appreciation is due to Mr.A.Amalavalan, my colleague from Health Affiliates India (HAI)/CCOORR who is basically responsible for this production. I have always been very proud of my team of colleagues from HAI and CCOORR who are responsible for the high quality output of the institution; the team consisting of Ms.Mekala Rajendran, Mr.Lawrence, Mr.Selina Basker, Mr.Gandhi, Mr.Venkatesh and Ms.Rosa Joshi. Each one of them has a key role in this endeavour.

The much needed financial support for the production of this manual comes from "CORDAID", The Netherlands, to whom I register my appreciation and thanks.

I greatly appreciate the services rendered by the PEs of Tamilnadu in HIV/AIDS Prevention and Care & Support of infected people and remain grateful to these silent catalysts of social change.

The laborious task of going through the entire draft and making necessary correction and editing was done by Ms. Elena Ranjan, to whom I register my thanks.

I wish to thank my wife Dr. Girija Ravi Raj for her support to this work.

Last but no means the least, I greatly appreciate the consistent assistance provided by my daughter Dr. Rachna William in documenting my experiences.

At this juncture I must confess that the information provided about PE in this manual is the record of an experience and there are no major references except the APAC's training module. I acknowledge this factor as a weakness of this work.

I am committed to the regular updating of this manual and so I request the users to share their experiences of using this material. Meanwhile, I wish all the users a merry time of learning and great success in their work against the spread of HIV infection and in providing Care & Support to those infected in India.

It is highly recommended that prior approval is to be obtained before any translation of the original content is attempted.

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DEDICATION

This work is dedicated to CORDAID, The Netherlands,

a wonderful partner in my learning process.

Dr. RAVI RAJ WILLIAM

HOW TO USE THIS MANUAL

This manual consists of 6 chapters. Chapter 1 The Trainee – The Peer Educator, Chapter 2 The Facilitator of Learning – The Trainer, Chapter 3 The process of learning -The Training, Chapter 4 An Indepth into the Training, Chapter 5 The Training Schedule and the topics, Chapter 6 The key messages for PEs in a nutshell.

The Trainee – the PE chapter will bring out many experiences with Peer Educators (PEs) and differentiate them from (VEs). The second chapter deals with the Trainer who is going to train PEs. The third chapter elaborately deals with the Training component. The fourth chapter is an extension of the third chapter and deals with the Training methodologies and related issues exclusively, the fifth chapter consists of the PE Training schedule and topics and the sixth chapter provides essential key messages which every PE should remember at every given moment.

The chapters on Training, methodology, topics and schedule are presented only as a quick reference material. It needs lots of local experience and expertise to complement the information printed. In other words, lot of homework is necessary before organizing the training. It should be realized that the manual is only a guide and not a complete training manual for readymade use.

CONTENTS

THE TRAINEE – THE PEER EDUCATOR (PE)

The trainee – the Peer Educator is presented in the following format,

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1.2 Qualities of a Peer Educator in implementing HIV/AIDS program
1.3 Selection of Peer Educator
1.4 Peer Educator, the key to success in HIV/AIDS programs why?
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1.6 Peer Education process, an in-depth study
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1.1 Components of PE:

To understand clearly about Peer-Educator, it is essential to understand various components related to PE such as Peer, Peer-groups and Peer Education. The components are inter-dependent and complementary to each other.

1.1.1 . PEER

A "Peer" is a member of one particular peer-group. The peer remains in this group due to similarities like common interests, qualities, behaviors and aspirations. Moreover each peer's life dynamics will also be more or less similar. In other words because of these similarities, the "Peers" cling together as a group. To sumup the characteristics of peers are,

- Common qualities
- Belonging to identical peer-group
- Similar age group
- Same sex
- Same profession / working in the same place /studying together.
- Same interests
- Rapport and understanding with other members of the group.
- Same behavioural patterns and habits

1.1.2 PEER-GROUP

A "Peer-group" is a congregation of homogenous 'Peer' members. As far as, sexual behaviour is concerned, the experience is that in one peer-group there are 10 to 50 member peers. The peer-groups do not meet formally, but there is constant interaction, happening usually very informally, mostly the interactions are one-to-one or in small group meetings. Usually, the agenda of the interactions are experience sharing of all their ventures including sexual encounters. The incentives for the interactions are learning from one another and mutual admiration.

1.1.3 PEER-EDUCATOR (PE)

In STI, HIV/AIDS prevention program, a Peer-Educator is one who is

- a peer in a peer-group
- is willing to become a role model to his/her group by changing his/her high risk sexual behavior
- is willing to undergo an effective, simple training program
- is willing to share his/her learning experiences with his co-peers of the peer-group
- will bring out behavioral changes in Peers even by exerting Peer-pressure
- is willing to sustain his/her behavioural change and that of his/her peers

- is willing to share the behavioral change details and sustaining behavioral change information periodically with STI, HIV/AIDS program implementing staff

The selection of PE is based on only his willingness to execute the above tasks and not based on his/her communication skill or leadership qualities or dedication.

For example:

Taking into consideration, if a group of Female Sex Workers (FSW) (Peer-group) working in the brothel house. One FSW (peer) of the group who is helpful to the program implementor by sharing his/her groups' characteristics, qualities, habits and behaviors is to be selected as PE (Peer Educator).

1.1.4 PEER EDUCATION SYSTEM (PES)

"Peer Education System" (PES) is the process by which a PE gives scientific information and brings about the behavioral changes among the members of his/her peer-group by modifying knowledge, attitude and beliefs; PEs also encompasses the process of sustaining the behavioral changes of Peers and the process of periodical feedback to STI, HIV/AIDS prevention project staff. Thus to start with the peer education system brings about change at individual level. However in course of time, the effect of the change will be perceived at the level of the group and society, basically by modifying norms that could lead to collective action. In the long run these could be changes in programs and policies.

PES is the most important behavioral change strategy which happens on a horizontal plane (between equals) and is derived from several popular behavioral theories like Diffusion of Innovation, Theory of Reasoned action and Social Learning Theory. PES is a scientific process and is now being tried widely in the field of public health to reach the difficult audience and target groups.

PES is usually performed by one-to-one interactive educational process. It is followed by group interactions within Peer-groups towards sharing of learning, mutual correction, mutual admiration and appreciation.

1.2 Qualities of a Peer-Educator in implementing HIV/AIDS program:

- ❖ Belonging to the same community and speaking the local language
- ❖ Living in the same area/place
- ❖ Personally he/she should listen and talk to other Peers with ease
- ❖ Interested in helping to improve the health status of his/her peers without any expectations of remuneration
- ❖ She/he should be proud and confident of doing the service
- ❖ Available to service providers and peers at any time
- ❖ First he/she has to change his behavior and then that of his/her peers
- ❖ Willing to maintain minimal documentation
- ❖ Willing to cooperate in follow-up actions
- ❖ Willing to sustain his/her behavioral change and his/her peers
- ❖ Have the interest to disseminate the complete knowledge on what she/he knows about STI,HIV/AIDS to his/her peers clearly
- ❖ Without any hesitation provides information about his/her behavioural changes or those of peers of group to staff of STI/AIDS project.
- ❖ Should have interest in refresher courses.
- ❖ Possess the capacity of lobbying and persuasion
- ❖ Willing to graduate to different, appropriate levels after completion of work within peer circuit.

1.3 Selection of Peer Educator:

- ♥ No special qualifications like training skills, communication skills, interest in social work or literate status are considered.

- ♥ Identification of PE is done by the program staff by keenly observing the behavioral dynamics of the target peer-group, they can easily discover a potential PE; another method is that the program beneficiaries could mutually recognize prospective PEs for other High Risk Behaviour (HRB) groups. Prospective PEs are also likely to emerge from target audiences if needs assessment and situational-assessment exercises are undertaken periodically.

- ♥ All the qualities of PE mentioned in 1.2 could be applied.

1.4 Peer-Educator, the key to success in HIV/AIDS programs why?

- Opening the topic of sex & sexuality in Indian situation could be done by PEs without any difficulty.
- No distortion of messages by PE.
- Better questioning from learners and thus a two-way real communication channel established.
- PE also could explain the process he/she underwent towards behavioural change(BC) without inhibition i.e. comfort levels are very high.
- In the BC process, the rate of change in status from unawareness to awareness is accelerated.
- Direct checking of sustainable BC like talking about condom use & checking knotted condoms are possible by PEs.
- PE strategy is valued and accepted by both program implementers and program stakeholders.
- As far as accessibility is concerned, PEs are physically accessible to target audiences. For example especially in settings where FSWs (Female Sex Workers) are at work, Men having Sex with Men (MSM)'s soliciting places, IVDU's (Intra Venous Drug Users) dosing places, PEs are very much available.
- PEs are incredible communicators in the sense, that they have intense inside knowledge about peers and use appropriate language/ terminology and non-verbal gestures in applying pressure and hence this does not mean that PEs must have classical communication skills even though this is desirable.
- Peer-Education is cost-effective as the selection, training and the volunteer in peer groups may not involve a huge expenditure compared to that of outsourcing qualified social workers to do the same job.
- Scaling-up of the program to any extend is possible because of the availability of PEs as a local resource.
- One hundred percent people participation is assured by PE strategy itself; moreover attempts are being made towards empowerment of PE process, by involving them in program planning, implementing, monitoring and evaluation.
- PE system could be integrated with other related activities of HIV/AIDS program like care and support of PLWHA; for that matter PEs could be related with other Health and Development programs too, a classical example being formation of women PEs as Self Help groups.

1.5 Peer- Educator selection, Change from intervention theme to theme in HIV /AIDS programs?

Yes, there is a lot of change in selection of PEs from one theme to another in prevention & control of HIV/AIDS programs and Care & Support of the infected. Experience reveals that in some programs, peers of a particular primary circuit may not be effective as PEs in exerting peer-pressure. This means the peers of a peer-group may be scattered in the secondary circuits also. The classic example is the truckers intervention program. Here, the secondary target community members like road-side restaurant people, vulcanizing shop people, fuel filling station people serve as more effective PEs compared to truck drivers / crew members themselves. The reason is truck drivers consider the secondary circuit group members as supporters. On the other hand, the PE system has completely collapsed in some programs, if secondary circuit members are used as PEs for the primary circuit. A classic example is, using madams / pimps as PEs in the FSWs' intervention program. Here, the impact is negative, the reason being the fact that, intuitively, FSWs do not accept madams/pimps as peers but fear them as exploiters.

1.6 Peer Education process, an indepth study:

Peer Education System in HIV/AIDS programs, when correctly and effectively implemented reveals many valuable lessons. An in-depth look into the process of the education brought out exciting information. The peer members of a peer group, with the introduction of a PE and his activation of the education process, fall into four circuits, based on their attitude towards new learning. Again they separated from each other by a very thin line. This process of learning is termed in this manual as **4 i system**.

4 i Peer Education Circuit diagram

The first circuit comprises of Instant Peers who see the behavioural changes in their PE, without questioning accept the teaching, change themselves and sustain their behaviours. The next group of Peers is Inter subject dialogue Peers, during the education process indulge even in intense deep dialogue on the subject just to know more on the subject and accept PE as the role model, in course of time change and sustain behavioural change. The third peer group is

the Indefinite group who will get convinced about the behavioural change of PE but for ego problems and group dynamics within the group, postpone the behavioral change for indefinite time, but finally changes. This group may immediately change behaviours but will not reveal it for a period of time. The last group is the Indifferent Peers, who always want to argue and pretend to be not interested just because their friend is providing information and want to show off that they also know more on the subject, they will be only looking forward for an outside expert to talk to them, here the challenge of PE is not to waste time on this small group but to promptly introduce them to an outside teacher, the project staff. Once the staff talks to them the behavioural change is instant.

This process model in the dynamics of Peer Education system is not based on the process of behavioural change where a person from the stage of unawareness or any other stage in the process, ends-up with the adoption of behavioural change. The explained model is purely based on peer group dynamics where at the moment in Tamilnadu most of the high-risk Peer group members belong to the informed / aware status. The Peer Education system does not take them through the other stages of behavioural change but cut-short the whole process, but only the attitude of some peer members towards their own peer form the base of these circuits.

1.7 The difference between classical education and peer education system:

CLASSICAL EDUCATION:

In classical education, the trainer is better qualified or knows more than the trainee will train the trainees. There will be a clear group demarcation between trainer (teacher) and trainee (student). Usually by this method, only information is transferred towards knowledge gain, but this process may or may not induce behavioral change.

PEER EDUCATION SYSTEM

Here, the trainer changes his behavior, realises and enjoys the benefits, places himself/herself as a role model and educates his/her peer-group members about the benefits he/she is enjoying. This process leads to knowledge gain in his/her peer-group members who in turn adopt their PE's behavioral change for themselves and sustain the same.

Comparison Matrix - Classical Education and Peer Education System

CLASSICAL EDUCATION	PEER EDUCATION SYSTEM
Trainer is qualified, highly knowledgeable and experienced person	Trainer is one who is equal in all respects with trainees except in his/her newly acquired knowledge.
There will be a clear demarcation and gap as Teacher and Student	There is no such demarcation or gap, all are equal.
Trainer only transfers information	Influences for behavioral change
Training is aimed at imparting new knowledge	Here Training is aimed at internalizing the new skill and practicing it
Through new knowledge gained, there may or may not be behavioral changes	Brings about sustainable behavioral change
Only advising takes place	Role modeling and Peer-pressure takes place
Follow-up after training is not easily possible.	Follow-up is the major activity and is possible
It is meant for the Development of Individual or community and is always for positive growth	Can easily be utilized for both positive as well as negative impacts in individuals & of course in groups
Trainings are usually time bound	Trainings are not Time bound but continuous
Time, Venue, Objective, Training Methods & Training content are pre determined	No such requirements, can happen at any place, time and duration.
Usually group learning	Usually Individual learning (one –to-one Interaction), sometime group learning
Lecture Method is most common	Participatory learning and two way communication at its best
Trainer may share other trainees' experience as example	Here trainer shares his/her own experience as example

1.8 Peer-pressure:

In the initial stages of peer education process, if the peer is indifferent towards the new learning, the Peer-Educator or peer-group can command and tell his/her peer that he/she is successful, so others should strictly follow what he/she says. Here there is no scientific learning process involved, only psychological pressure is applied; this is termed as Peer-pressure technique. By applying Peer-pressure one can bring behavioural change in STI, HIV/AIDS prevention and control activities. (Eg.) The Peer-Educator can insist on her peers using condoms.

1.9 Role of Peer Educators in HIV/AIDS prevention and control:

1.9.1 STI PREVENTION AND CONTROL: (IN GENERAL TERMS)

- Explaining and educating the peer-members about the basic methods of prevention of the disease is the number one task.
- Then helping the peer-members identifying their STI symptoms if STI present; initiating full complete treatment, partner treatment by referrals to trained doctors.
- Just after treatment or within a short time after treatment if the same symptoms re-appear and the PE realizes that it is relapse of the same infection because of the peer not taking full and complete treatment, the PE applies pressure for full and complete treatment.
- Combating myths and misconceptions at every instance and every given point of time.
- Educating the peers member negotiation skills for
  - safe sex with condom
  - safe sex without condom
- If there is infection reported among the peers after a period of time, realizing that it is a re-infection and is due to condom use failure and applying Peer-pressure for condom usage and again for full complete treatment for self and partner by trained Doctors, PE realizes the difference between relapse and re-infection.
- Motivating peers for HIV testing through Voluntary Counseling Testing Centre (VCTC) to detect early infection.

1.9.2 CONDOM PROMOTION (SPECIFIC)

- Explaining to peers about the usefulness of the condom (Disease prevention, birth control and pleasure)
- Demonstrating how to use a condom correctly and asking peers to repeat the demonstration

- Directing the peer-members to places where condoms are available
- Giving information regarding the prices of condoms
- Disseminating information about varieties of condom and encouraging members to try varieties of condoms to avoid familiarity.
- Distributing free condoms and selling low priced condoms.
- Identifying the peer-members' problem in using condoms consistently, if it is not practiced, as this is an area of major concern, if it is not practiced.
- Closely monitoring the condom users for the knots applied before condoms are disposed. This is a visible indicator of the impact of peer pressure.
- Insisting on the peer-members not using alcohol before sexual encounters.
- Disseminating information that for Oral sex separate flavoured condoms are available.
- Insisting on avoiding anal sex. If not, advising peers to use single condom with KY Gel lubricant.
- Warning peers about duplicate condoms availability in the market and not using unfamiliar condoms.

1.9.3 COUNSELING (SPECIFIC)

- Informing peers that counseling facilities are available in Government hospitals and with private agencies working for HIV/AIDS prevention programs.
- Informing peers that there are two types of counseling centers available, one is the Preventive Counseling and the second is Testing Counseling (VCTC). Peers must be informed that any problems, hesitancy or block related to accepting STI, taking treatment and condom usage will be solved in the first center; the second center deals with peers who want to test their blood to know their HIV status, to accept their status in a positive way and further if tested positive, will be helped to live a positive life.

1.9.4 ROUTINE MEDICAL CHECK-UP (RMC)

- Making the peer-members realize that RMC is absolutely necessary as far as FSWs, MSM; IVDUs and Trans Genders (TG) are concerned, to detect hidden/early STI and HIV infection.

- Moreover by RMC all other diseases are also detected, treated and for that matter even prevented.

- Initiating the peers to take RMC atleast once in every three months

- Linking peer-members to trained Medical Doctors (FSWs to lady Doctors and insisting on Pelvic examination with speculum)

1.9.5 RECORDING AND REPORTING

- Keeping minimal, simplified documents in order to have clear records of what is being done, what has to be done in the future (STI identified and treated; condoms usage, counseling referrals).

- Maintaining basic, simplified documents of their peer-members' RMC details and the future appointment for RMC.

- Reporting the above information on a prescribed format and sending periodically may be on a monthly / quarterly basis, to Government /NGO who may be a partner for AIDS prevention & control program, periodically, may be monthly / quarterly

- Sharing the experiences of self / peer-members wherever an opportunity arises.

1.9.6 SUSTAINED BEHAVIOURAL CHANGE

- This activity is a challenging one, only PEs can make their peers use condom in every sexual encounters and in case of FSWs, even with their husbands, other permanent partners and live-in partners

- Peer-Educators could verify randomly the sustained behavioural change in their peers by inspecting used condoms, by exit interviews after sexual encounters or by asking peers to narrate experiences with condoms.

1.10 PE Graduation Plan:

It is realized that PEs will complete their task of producing sustainable behavioural changes in peer-members of their own groups in about 4-6 months time (maximum 50 in number). This warrants planning for the future of PEs before PEs reach the burnout state.

* Peer-Educator could develop his/her peers as Peer-Educators for new groups by training. In other words, developing one line of peers as subsequent lines of Peer Educators

* Peer-Educator could convert his/her peer-groups into Self Help Groups (Community Based Organisations) for economic independence or they could amalgamate into existing Self Help Groups (SHGs), the later option being more sustainable

* Peer-Educator could update his/her knowledge and skill by attending more and more training programs and graduate to a level of effective trainers to PEs and Volunteer Educators (VEs)

* Peer-Educators could form a Satellite group and thus converting the activities into movement of people, again towards sustainability

* Peer-Educators could involve themselves in program planning and program implementation regarding STI, HIV/AIDS and in expansion of the project as well as for ongoing programs

* Peer-Educators could plan programs in order to combat other health problems and thus attempt integration into other ongoing programs of the Government as well as NGOs

* In a nutshell, PEs should have a retirement plan once they retire from active activation of their circuits i.e. after they complete producing sustainable behavioural changes among all their peer members.

1.11 Peer-Educator documentation in HIV/AIDS prevention and control programs:

As seen earlier, Peer-Educators could be collecting key information and documenting it once a month since long term basis collection can lead to bias and loss of credibility. It is good and optimal to collect information on a monthly basis.

Documents could be maintained in two types if possible, if not, group model format could alone be maintained. Another innovative model is also developed. The PE/project is free to use either one.

FORMAT I.

Individual Model Format (for a PE who can read and write)
(for every peer, the PE fills single form)

Name of PE :
Name of the Peer :
How long existing in the Peer-group :
Peer Number in the group :

1. In the month, how many sexual encounters did she/he have Commercially? ___
1.1 Did she/he uses condom in every sexual encounter Yes/No
1.1.1 If no, mention the reasons
a) _____ b) _____ c) _____ d) _____
1.1.2 If yes, how did he/she negotiate?
a) _____ b) _____ c) _____ d) _____
2. In the month, how many sexual encounters did she/he have with her husband/spouse (in numbers for FSWs and TGs) ___
2.1 Did she/he use condom with her/his husband/spouse Yes / No / rarely
2.1.1 If not, mention the reasons
a) _____ b) _____ c) _____ d) _____
2.1.2 If yes, how did she / he negotiate?
a) _____ b) _____ c) _____ d) _____
2.1.3 If rarely, why only rarely?
a) _____ b) _____ c) _____ d) _____
3. Did she/he have STI symptoms this month Yes/ No
4. Did she/he go for counseling this month Yes /No
4.1 If yes, what are the reasons
a) _____ b) _____ c) _____ d) _____
5. Did she/he attend Routine Medical Checkup (RMC) this month Yes /No
5.1 If yes, what are the findings and actions taken?
a) _____ b) _____ c) _____ d) _____
5.2 If no, what are the reasons
a) _____ b) _____ c) _____ d) _____
6. Did she visit VCTC services this month Yes / No
6.1 If yes, is it first visit or a subsequent visit _____
6.2 What is the result _____

FORMAT II.

Group Model Format

In your peer-group,

1. How many peers are there
2. Total number of commercial sexual encounters in the last month
2.1 How many of them used condom in every sexual encounter
2.2 How many of them did not use condom in every sexual encounter
2.3 How many of them used condom consistently with their husband
3. How many used condoms,have you crosschecked in disposed places
3.1 How many sexual encounters did you anticipate from your peers who dispose condoms in the particular place you inspected
3.2 How many condoms did you find at a given time
3.3 How many-knotted condoms were found among them
4. How many of your peers are using condom
5. How many condoms have you distributed within this month's time
6. How many condom demonstrations were done during this month
7. How many peers reported for STI during this month
7.1 Of the STI patients, how many of them took full complete treatment
7.2 Of the STI patients, how many brought their partner for treatment
7.3 Of the STI patients, how many of them had re-infection this month
7.4 How many of STI peers have the following symptoms,
   a. White Discharge _____ b. Ulcer
   c. Inguinal adentities _____ d. Lower abdominal pain
   e. Burning Micturation _____ f. Scrotal pain and swelling
   g. Others specify _____
8. In a month how many one to one interactions you have performed
9. In a month how many small group meetings you have performed
10. How many peers attended VCTC
11. How many underwent RMC
   a. 1st cycle ___ b. 2nd cycle ____ c. 3rd cycle _____ d. 4th cycle

9. Major achievements in the month

_____

Narrative

Any other relevant information / case study

_____

FORMAT III.

If illiterate, an Innovative Register – the pyramid documentation

If illiterate, a Novel Register could be maintained, which is termed as Pyramid documentation and will be a monthly exercise.

Reporting Month:

Name of PE :

P E

STI	S
Condom	C
RMC	R
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 1

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 2

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 3

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 4

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 5

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 6

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 7

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 8

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 9

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 10

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 11

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

Peer 12

S	
C	
R	
month	1 2 3 4 5 6 7 8 9 10 11 12

How to fill the Register

Instructions:

1. For more peers increase the base and add ☐

2. ☐ 1 box is for one peer and her /his sustainable behaviours are marked by using coloured ✔. The exercise is repeated every month, one box is for a period of one year.

3. a) STI Treatment (Yes, Red ✔ & No, Red –)

   b) Condom consistent use (Yes, Green ✔ & No, Green –)

   c) RMC (Yes, Pink ✔ & No, Pink –)

For Example:

Peer Seetha (Female Sex Worker)

STI	**(Red colour)**	–	✔	–	–	–	–	–	–	–	–	–	–
Condom	**(Green Colour)**	–	–	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
RMC*	**(Pink colour)**	–	–	–	–	–	✔	–	–	–	✔	–	–
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

* RMC – Routine Medical Checkup

Inference:

Peer Seetha on 1st month was resistant to all behaviour changes; 2nd month noticed STI, took treatment; 3rd month started on condom, STI cures, she continued throughout the year with condom, on 6th month she had her induction RMC and then 10th month 2nd cycle RMC and next year second month she will go for 3rd cycle RMC.

1.12 A Register for the Project on PE system:

I G D

PE WORKING INFORMATION GATHERING DISSEMINATION (IGD) ANALYTICAL MATRIX

Name of Peer-Educator :
No. of peers in the circuits :

Date of Registration of PE :
Name of Project staff who did IGD :

Date of interaction with project staff	Reporting period (since last reporting)	PE Training Details		No.of peers		No.of One-to-one interactions	No.of group meeting	STI referrals				Counseling		Condom distribution		Referral for RMC	IEC distribution how much	VCTC referrals
		Induction Training	Refresher training	Available no.	On consistent condom no.			Referred	Treated fully and completely	Partner treated	Reinfected	referred	Followed up	free	sales			

1.13 Volunteers:

Volunteers are those who are members of the community at large who on their own, physically perform activities for any project which include education of the general community and target population in HIV/AIDS prevention & control program as well as Care & Support of PLWHA.

1.14 Volunteer Educators (VE):

VEs are volunteers who are willing to learn and teach, to undergo systematic training and disseminate learning to any member of the general community, in HIV/AIDS programs, they will talk about the disease, prevention & care and support in general terms.

1.15 PE, VE Matrix in relation to HIV/AIDS programs:

S.No	Components	Peer Educators (PEs)	Volunteer Educators (VEs)
1.	Population to which related & working for	Visible HRB groups	general population
2.	Selection	No set procedure but anyone approachable and available from HRB groups	Process of careful selection is necessary, those who have social concern & communication skill are selected
3.	Methodology of working	Brings about behavioural change in himself /herself and in his / her peers like changing to condoms, treating STI and undergoing Routine Medical Checkup (RMC)	provides right information about STI, HIV / AIDS and condoms to general population
4.	Working pattern	Highly focused and works with his/her peer circuit members only	Not focused,but to address any available general population.
5.	Exhibiting Skills	Exhibiting skills developed during training like condom demo, is equally important like disseminating theoretical learning	Disseminating theoretical learning is more important than exhibiting skills developed
6.	Ultimate referral point	HealthCareProviders,Counseling Centres	Counseling Centres
7.	Activation period	Work till all the peers of his/her group change their high risk behaviours and sustain it. After this major task, PEs will attempt working with individuals belonging to same profession / casual contacts; if not reach burnout stage and stop functioning.	Permanent asset; continue to work with new communities and will not reach burnout stage
8.	Aspiration in professional achievement	Could be networking with other PEs and starting a movement, could be promoted as Trainers / local consultants to programs	There will be always demand for further training and graduation to many higher levels based on their specific skills & qualifications
9.	Change of role	PEs of HRB groups can graduate as VE in another geographical area only	Cannot become a PE in another geographical area or in own area.
10.	Role model nature	Will be a role model for the specific peer-group.	Invariably turn to be a social worker to the local community, cannot be a role model in HIV/AIDS programs
11.	Incentives	Performance related incentives and incidentals could be paid; No salaries needed.	No performance related incentives & salaries; Incidental expenses could be provided

CHAPTER II

THE FACILITATOR OF LEARNING – THE TRAINER

The essential of the trainer of Peer Educators (PEs) is considered under the following headings:-

2.1 Qualities of the Trainer

2.2 Essential skills required for the trainer

2.3 Knowledge base of the trainer

2.4 Self Appraisal by Trainer

2.1 Qualities of the Trainer:

- Trainer should believe that trainee is the major "resource" and hence from the trainee, the trainer could get useful additional information
- Trainer should have an empathetical approach towards trainees
- Should avoid focusing (or) pointing at individuals of a group directly
- If an individual trainee of a group is unable to answer a question, he/she should not be further probed (non threatening)
- Trainer should project himself /herself as an example / role model
- Trainer should encourage the trainees to participate in the program.
- Trainer should maintain confidentiality of the group's dynamics and knowledge levels.
- Trainer should encourage the trainees to ask questions

- Trainer should have a strong belief and confidence that the training would create positive changes in the trainees
- Trainer should analyse merits and demerits of the training content and method with other trainer
- Trainer should project himself as one among the participants
- Trainer should facilitate and develop trust among group members
- Trainer should avoid opposing the comments and views of the participants
- Trainer should express trainer's view in a way that is acceptable to the participants
- Trainer should respect and recognize the views of participants
- Trainer should bring out the link between the previous session and the next session
- Trainer should get assurance from the participants that they will practice what they have learned
- Trainer should give an assurance to the participants that after the training, continuous learning facilities will be available
- Trainer should decide on how much time could be spent for the question and answer session.

2.2 Essential skills required for the trainer:

The trainer should,

- ➔ speak slowly, clearly and in an understandable way,
- ➔ use simple language,
- ➔ avoid using microphones,
- ➔ conduct Need-assessment of the trainees before training,

- design the training content based on needs assessment,
- strictly follow the training time-schedule,
- pre-plan the activities to be carried out,
- express wide range of genuine human emotions,
- avoid long sentences and jargon,
- control the group during crisis / problems due to difference of opinions within the group,
- utilize effective training materials in-order to maintain participants' concentration,
- explain the training content before start of the training as introduction,
- end the training program by consolidating the content,
- must have the competency and capacity to use the latest training aids properly,
- see that the gestures are relevant to the activities,
- update the training skills,
- should create a positive group-dynamic among the participants through ice-breaking session in training,
- ask encouraging questions which will make participants to participate in the program and give elaborate answer,
- measure the quality of informations that have been transferred,
- analyse the views of the participants positively,
- instead of trainer deciding on what is good / bad, decisions could be left to the participants.

2.3 Knowledge base of the trainer:

- Trainer must posses an in-depth knowledge and concept clarity of the training content
- Trainer should update himself with latest scientific information
- Trainer should know the latest updated statistical details (especially the local situation)
- Trainer should know about the full program with fine details and also know how the training would be related to the program
- Trainer should explain the importance of why the trainees should know the content of the training

2.4 Self Appraisal by Trainer:

Trainer has to do self appraisal by measuring the difference in his / her performance by comparing it with his / her earlier training performances.

Merits of Self Appraisal:

- Self analysis by the trainer will provide an opportunity to understand present difficulties and the areas requiring improvements for future perfection
- Self analysis by trainer will be realistic, complete & correct
- Self analysis is independent and will not create any mental pressure since there is no external criticism involved

CHAPTER III

THE PROCESS OF LEARNING - THE TRAINING

The training component is considered under the following frame:

3.1 What is Training

3.2 Pre training activities

3.3 Activities during training

3.4 Post training Activities

3.5 Training related checklists

3.1 What is Training:

"Training" is an event in a learning process; trainees being a group, given a contusive, controlled environment, for transfer of correct and scientific information; whereby there is knowledge level improvement and skill transfer which leads to changes in the groups' behaviour / attitude / practice.

3.2 Pre – Training Activities:

First-trainer and Trainee should understand the objectives and needs of the training, before starting the training program

3.2.1 FORMULATING OVERALL OBJECTIVES OF THE TRAINING

The overall objectives of training PEs may be either one or all of the following training objectives.

1. PEs to know, what is STI and HIV/AIDS
2. PEs to know provision of care and support activities for People Living With HIV/AIDS (PLWHA)
3. PEs realize the importance of their roles towards themselves and their groups in prevention and control of HIV/AIDS
4. To educate PEs on various sexual behaviors which increases the risk of HIV/AIDS, STI infection
5. PEs understand that women are more prone and vulnerable to STI, HIV/AIDS infection
6. PEs to know the importance of full, complete treatment and partner treatment
7. PEs to know where STI quality management services are available
8. PEs to know and provide information about condom usage, varieties, availability, costs and duplicate condoms
9. PEs to develop negotiation skills for using condom and safe sex without condom
10. PEs to combat myths and misconceptions prevailing among their peers about STI, HIV/AIDS, condoms and sex & sexuality
11. PEs to realize the importance of counseling and behavioral change communication activities in prevention and control of STI, HIV/AIDS
12. PEs to encourage sustainable behavioral changes towards safe sex within themselves (PEs) and in their group members
13. PEs to realize and decide their graduation plan.

3.2.2. TRAINING NEEDS ASSESSMENT (TNA)

Training Needs Assessment refers to the process of finding from Trainees what they want to learn under the overall objectives of the training and hence measures the gaps to be fulfilled. This could be done by questioning the entire group of a particular training or on a random sampling of the trainees.

Example: The overall objective of the training may be providing knowledge about STI to PEs, in which the usual TNA is that the trainees want to know about the symptoms of STI rather than how the diseases progresses in a human body.

Moreover the needs assessment exercise should include measurement of the present knowledge, attitude and practice of the trainees. This will enable in planning the competency model of curriculum development and training.

A Sample Needs Assessment Form

Participant's name, age, category, date on which training needs assessment done.

Questions:

a. What do you know about HIV/AIDS?
b. What do you know about STI?
c. What do you know about Condom?
d. What is the motivating factor for your participating in this training?
e. Have you ever attended similar training programs before?
f. What do you want to learn from this training?
g. How do you want this training program to be conducted?
h. In what way do you think this training will be useful to you?
i. Where and when shall we have the program?
j. Do you know who treats STI and HIV/AIDS in your town /village?

3.2.3 COMPETENCY TRAINING MODEL

Competency training model consisting of the following

- After assessing the needs of participants, prioritizing the needs
- Finding the gaps between pre fixed training objectives and TNA
- Training content is developed
- The contents are prioritized
- The time schedule for each item of the content is decided
- For each item of the content learning objectives are framed
- Determining the methodology of the training (the training methodology is separately dealt in the next chapter)
- Determining the measuring plan for the training
- Planning the logistics of the training

Designing learning Objectives (SSMARRT)

should be

1. Simple
2. Specific
3. Measurable
4. Achievable
5. Relevant
6. Realistic
7. Time bound

Learning objectives should be specific to knowledge, skill or attitude. Only importance is that the objectives should be different for each activity (i.e) separate for knowledge, separate for skill and separate for attitude and behaviour. For one overall objective, it is desirable to make one / two learning objectives only. Usually behaviour changes could be studied only during followup of the training.

An example of a learning objective:

- By the end of the 30 minutes session on correct use of condom, atleast 90% of the PE trainees will be able to describe 10 steps of correct use of condom (knowledge);

- by the end of the 30 minutes session on correct use of condom, all the PE trainees will correctly perform a condom repeat demo (skill);

- by the end of the 30 minutes session on correct use of condom, 90% of the PE trainees will assure correct use of condom during all their penetrative sexual encounters which includes Peno vaginal, peno anal and peno oral sexes (behaviour).

3.3 Activities During Training:

TRAINING HALL

- Spacious square shaped hall is the best, without any interior decoration and external disturbance.

- Hall should not be too big and at the same time, it should not be less than 20 meters length and 20 meters breadth with seating facilities for 15-20 members.

- ♣ Room should have good ventilation.
- ♣ Environment must be congenial for group learning.
- ♣ The location should be such that the trainees shall feel confident enough to openly discuss their sex and sexuality.
- ♣ In the hall, there shall be no one else but for the trainees & trainers.
- ♣ Avoiding telephone calls, mobile phones and such other gadgets during the training program is a must.
- ♣ Training Room shall not create a classroom environment

SEATING ARRANGEMENTS

- ♠ No separate seating arrangement for the trainer, it shall be similar to that of trainees.
- ♠ U- shaped seating or O-shaped seating arrangements with space for free mobility of participants is ideal.
- ♠ Participants shall feel comfortable with seating.

OTHER FACILITIES

- ♥ Electrical facilities to be checked for consistent power supply, a standby generator shall be arranged.
- ♥ Arranging safe drinking water and toilets facilities etc. are very important.
- ♥ Good lighting – tube lights should be provided.
- ♥ Microphones should not be used.
- ♥ The room should be sound proof.

TRAINING MATERIALS CHECK LIST

- Registration format
- Teaching tools (i.e.) O.H.P, Slide projector, flash cards, games materials, etc.
- I.E.C materials
- Penis models
- Condom varieties
- Gift articles
- Marker pens, white board and charts
- Reference books
- Feed – back format
- Writing pads and sheets

DETERMINING TRAINING TIME PERIOD AND CONTENT DURING TRAINING DONE WITH PARTICIPATION OF TRAINEE PES

- Further fine tuning of content and timing.
- Each session of training shall not exceed 45 minutes.
- In every session, optimal time has to be allotted for open discussion where the participants can debate or speak-out their views & clarify their doubts.
- To encourage participants to participate, methods such as Group discussion, Role play, games and case studies are to be used.
- There should be sufficient time for lunch & tea breaks.
- While explaining the objectives of the training, separate time has to be allocated to explain the training method.
- Starting time and ending time of training session has to be determined in a participatory way.

RULES AND NORMS TO BE FOLLOWED DURING TRAINING PROGRAM

Basic rules and norms to be followed by Trainers are explained in chapter 2 (Trainer section)

Basic rules and norms that to be followed by Trainees is to know trainers role as explained. They shall be motivated to follow the same. Some important ground rules are,

- Maintaining punctuality
- Maintaining confidentiality about training
- Respecting each other
- Complete Involvement in Training
- Trainees have to participate and write their comments without any hesitation
- Only one person has to speak at a time
- One can accept or oppose others' views,
- Trainer could designate among the group–one as Manager to conduct program, other as Evaluator to measure the quality of the program and another as Recorder to document the happenings of the program.

HOSPITALITY

1. Hospitality has to be arranged according to the needs of the participants.
2. Sufficient safe drinking water facilities and food facilities have to be arranged in quality manner and to be provided at right time.
3. Sufficient break has to be given for lunch & tea
4. Trainees urgent needs to be met.
5. Incentives and gifts could be given to motivate participants to participate actively, preferably based on training performance.

GROUP INTRODUCTION (ICE-BREAKING SESSION)

An ice-breaking session has to be conducted in order to make the participants understand each other and develop a relationship to make them free from fear and to participate actively in the training program.

TO MANAGE TIME

- Clarity is necessary about training content, training method, time period of training
- Starting the training at the scheduled time is important
- Conducting the training according to the time schedule is a basic rule.
- Closing the training as per the fixed time is also important
- Avoiding unnecessary discussions
- Based on the learning objectives utilizing the time effectively

ENERGIZES

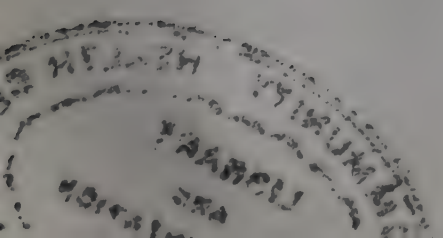
Energizes are simple games to be introduced in a Training program periodically. These games give physical and mental relaxation and keep the energy level of the trainees at an optimum level. Atleast once in two hours, a game has to be introduced which could be performed in 10 minutes time.

3.4 Post training process:

3.4.1 MEASURING EFFECTIVENESS OF THE TRAINING IMMEDIATELY AT THE END OF THE TRAINING – A SAMPLE FORMAT

3.4.1.1 Questionnaire General aspect (could be selectively used or fully)

Questions	Yes	Doubtful	No
Are the learning objectives properly explained?			
Is everyone given equal importance during training?			
Are the trainer's body gestures relevant to the activities?			
Are the participatory learning methods useful?			
Are relevant examples used?			
Are the participants motivated to ask questions freely?			
Are the participants controlled at the required situations?			
Are the participants' indifferences dealt with without hurting anyone's feeling?			
Is useful information disseminated to participants?			
Is the accent simple and understandable by all?			
Is the information simplified for the understanding of all participants?			
Does the trainer communicate in an audible voice?			
Are the training methods appropriate, comfortable and relevant for the training?			
Are appropriate teaching tools used?			
Are the training objectives fulfilled?			
Are the learning objectives fulfilled?			
Is the participants' knowledge gain measured?			
Question related to venue, time, hospitality and punctuality could be added			



3.4.1.2 Questionnaire specific to learning objectives

For every learning objective, questions could be formed. For example, regarding correct use of condom.

Questions may be

1. How many steps are there in condom usage?
2. Where should the condom be stored at home?
3. Where could used condom be disposed? Give 3 places
4. What is the main cause for condom bursting during sexual encounters?
5. Why knot is applied before disposing the condom?

3.4.1.3 Sessional Evaluation format

Every session could be evaluated quickly. In evaluation format name and address are not required.

Evaluation Model Format

Activities	Good	Satisfactory	Not Satisfactory
Content of the session			
Method of the training			
Use of audio visuals			
Two-way communication			
Trainers capacity			

Your suggestion for future improvements:

3.4.1.4 Assessing knowledge / skill gained

A. ***Questioning:***

By questioning the trainees randomly, trainer could evaluate the training, depending on their reply. A wide range of simple questions to be selected on the trainings, it could be selected questions from learning objectives.

Another method is by using same set of structured Pre-test questionnaire and post-test questionnaires, one can evaluate the participants understanding of the program by analyzing the difference in the percentage of correct answers between pre and post test questionnaire. This is a useful and quick way of measuring the training specifically.

Third method is using the brain storming technique (explained in the methodology chapter) with the trainees by the trainer.

A Sample questionnaire:

1. What is the link between STI and HIV/AIDS? _____
2. Is HIV completely curable? Yes / No
3. What are the important major symptoms of STI?

For men		For Women	
a).	_____	a).	_____
b).	_____	b).	_____
c).	_____	c).	_____

4. What will you do if you are infected with STI _____
5. What has to be done to prevent STI _____
6. Do you think condom has to be used in every sexual encounter Yes/No
7. How many varieties of condoms are available in the market _____
8. Why condom has to be knotted after using? _____
9. Can you state, one condom negotiation technique? _____

B. ***By sharing trainees' training experience and thus evaluating the training:***

The trainees could be motivated by the trainer to share their training experience and lessons learned. By carefully studying this exercise, the quality of the training could be measured.

C. ***Trainer's Peer Review and evaluation of the training:***

There could be colleagues of trainer from the project, other trainers of the training, friends of Trainers or even invited evaluators, all of these categories form Peers of Trainers. All these group members could be provided with a structured format and encouraged to evaluate the program. This method of peers evaluating is emerging as an effective tool in the whole process.

3.4.2 FOLLOW-UP OF THE TRAINING

It is important that the trainer himself/herself follows-up the trainees in the field to measure the effectiveness of the training imparted apart from the exercises mentioned earlier. The measure could be on knowledge level, skills acquired and behavioural changes, separately or all together. The frequency of the followup to be at regular intervals, starting from one month after the training, then atleast half yearly, for a period of 3 years.

The methods of followup could be through

1. questionnaire general and specific
2. Peer reviews (questioning colleague PEs who underwent the same training at the same time)
3. observing the dynamics of PEs by Trainers or through Key informants

3.4.2.1 Questionnaire Technique (sample to be used for followup):

Sample follow-up format, Trainer reviewing Trainee

Peer Educator Name :
Address :
Interviewing Date :
Last Interviewed Date :
Dates of Training :
Total number of Peers in PEs circuit :

General

1. Is the information given clearly understood by trainee?
2. Is there any distortion of the information given during the training?
3. Does the trainee show behavioral change towards consistent condom usage yes /No
4. What is the best learning from the training?

Specific questions:

A. Information about STI

A.1 After training /last Interview, how many had STI in your circuit ____

A.2 In your circuit how many of them had following STI symptoms

Genital ulcer /Bluster's (male/female) _____
Genital pus like discharge(Male/Female) _____
Inguinal adenities (Male/Female) _____
Burning Sensation during urination (Male/Female) _____
Lower abdominal pain (Female) _____
Pain in testes and swelling (Male) _____

B. Quality STI Care

After training /last interview in your circuit,

B.1 How many are referred to take full complete treatment from trained doctors?
B.2 Of which, how many of them consulted trained doctors _____
B.3 Of which, how many of them took complete & full treatment _____
B.4 How many of them, got their sexual partners treated? _____
B.5 Is there anybody who is re-infected after taking treatment for STI? (New infection condom failure) _____
B.6 Is there anybody who has relapse after taking treatment for STI? (existing infection reappears, treatment failure) _____

C. Condom Promotion

C.1 How many condoms totally you have distributed to your peers/ month? __
C.2 How many of your peers are using condoms correctly & consistently? ___
C.3 How many of your peers are using free condoms? _____
C.4 How many of your peers are purchasing priced condoms from shops?___

D. Quality Behavioral Change Communication (QBCC)

D.1 How do you interact with your peers, one to one / one to group? _____
D.2 On an average per month per peer, how many interactions are there?___

E. Other Information

E.1 How much time per day do you spend on STI, HIV/AIDS prevention activities? ____
E.2 How much income do you generate by selling free or priced condoms? __
E.3 Do you feel mentally satisfied by working in HIV/AIDS prevention work? Yes / No
E.4 Do you think community recognition and respect has increased because of working in HIV/AIDS prevention activities? _____

3.4.2.2 Methods other than structured questionnaire technique used during follow-up

- In – Depth Interview (IDI)
- Focus Group Discussion (FGD)

IN DEPTH INTERVIEW (IDI)

Indepth interview is a method of collection of information / assessing the impact of a program or training / assessing a situation, from beneficiaries / Trainees of a Training / informants, through one to one interaction, using structured / semistructured questionnaire or by casual talk.

Steps In In-depth Interview

I Preparing Interview questions and preparing a structured format (other than casual talk method)

II Conducting In depth Interview

- Greeting the Trainee (informant)
- Introducing Trainer (interviewer)
- Explaining reasons for the interview
- Seeking permission for recording by giving reasons and assuring confidentiality
- Conducting the interview
- Getting clarification whenever necessary
- Confirming information
- Closing Interview by thanking and talking about how the information will be utilized and would be beneficial for the trainee / informant
- Assuring about followup interview and probably planning the same

III Analyzing and Interpreting the information for inference

Additional informations on Quality Indepth Interview

- Asking probing questions are desirable
- Repeatedly asking questions are permitted
- Determining interviewing method and interviewing questions from the sample formats are useful.
- Interviewer not to lead answers (allowing trainee to speak out)

- Trusting trainee to be an expert and a local resource
- Appreciating the trainee now and then for his/her cooperation
- Encouraging the trainee to narrate and elaborate the information provided
- Conducting Interview in a friendly Environment
- Recording trainees' information by writing and recording in tape after consent.
- Trusting the information given by the trainee

FOCUSED GROUP DISCUSSION (FGD)

FGD is an informal yet formal method of collecting information / assessing the impact of a program or training / assessing a situation from beneficiaries / Trainees of a Training / informants, through small group interaction technique, where a facilitator guides the group towards specificity.

Players of FGD

1. **Facilitative moderator** – who facilitates the program in a highly focused manner
2. **Recorder** – Records the full events and deliberations
3. **Participants** (Trainees/beneficiaries selected)

Method of FGD

6 – 12 participants sit in a closed circle alongwith the facilitating moderator. The recorder sits in the outer ring. The moderator facilitates interaction based on an already framed topic guide.

Preparation of Topic guide

In the process of preparing the Topic guide, the following criteria could be followed,

- ➦ Define the topic for the FGD based on the objective / issues to be addressed by the exercise
- ➦ Probing and open-ended question
- ➦ Avoiding too many related questions
- ➦ Avoiding questions that will be answered as Yes/No
- ➦ Questions shall initiate debate
- ➦ Each question should take a minimum time

Example for Topic guide questions

In what specific way, has the training you have undergone helped in working with your peer groups?

Is there any problem in discussing with your group about problems in using condoms?

What are the problems your peer group experience on utilising a Doctor's clinic during waiting, examination, prescribing time, instruction-giving time and walking out of the clinic?

Specific objectives of topic guide in HIV/AIDS prevention and control

a. Information about quality STI care
b. Information about Counseling and its usage for peers
c. Information about condom varieties, availability, cost, correct usage consistent usage and disposal
d. Information about condom negotiation skills
e. Information about negotiation for non-penetrative sex.

Role of Facilitative Moderator in F.G.D.

- ❑ Shall not be a question & answer session.
- ❑ Expect multiple answers.
- ❑ Express ignorance about many issues discussed and not try to correct answers coming up.
- ❑ Not to be acting as an "expert" and "Judge".
- ❑ Keep group focused to informations to be collected.
- ❑ Speak briefly and clearly to group.
- ❑ Make participants talk and not dominate deliberations.
- ❑ Not to Interrupt when participants express their views.
- ❑ Get the approval of the group for decisions taken.
- ❑ Avoid Interviewing one by one, but randomly use topic guide and illicit information.
- ❑ Avoid rigid planning of the session and allow flexibility.

Steps in Setting FGD

STEPI	-	Specifying objectives of the exercises
STEPII	-	Developing Topic Guide
STEPIII	-	Choosing specific participants (Trainees)
STEPIV	-	Selecting Ideal location for conducting the program
STEP V	-	Introducing facilitator, explaining ground rules, ensuring confidentiality, explaining that there is no right or wrong answer, accepting the quality of the information
STEP VI	-	Conducting the FGD as per the discussed criteria, process and plan
STEP VII	-	Closing the FGD with the assurance that the information provided is confidential, will be used only for the betterment of the trainees / participants and at large the target community; there will be a summingup of the discussion by the reporter and there will be an assurance about followup and could be a planning about followup.

3.5 Training related checklists:

3.5.1 PRE TRAINING ACTIVITIES CHECKLIST

Activities	Done	Not done
Training Needs Assessment		
Training planned		
Training content and teaching tools are determined		
Facilitators of training selected and informed		
Location/Venue of training is determined		
Participants are visited and invited for training		
In consultation with participants training date is determined		
Reference books / handouts to be given to participants during the training are collected		
Budget and materials required for training is planned		
Planning lodging and boarding done		
Determining incentives or gifts to participants		

3.5.2 DURING TRAINING CHECKLIST

Activities	Done	Not done
Receptionist arranged to welcome the trainees		
Checking the required training materials availability		
Registration format is made available to register participants		
Conducting ice breaking session		
Time management		
Explaining learning objectives and frame for each training		
Checking whether trainees are involved in the program		
Checking whether updated scientific informations are given during the training program		
Usage of teaching aids evaluated		
Measuring the quality of information received by participants during training (by asking questions and getting clarification from the participants)		
In consultation with participant post training follow-up method is determined		
After training, checking whether trainer evaluated the training program		
Checking whether participants are given the information about medical facilities and names of trained doctors.		
Information given about condoms		
Information given about counseling		
Whether participants are motivated to contact trainer at any time without hesitation		
If participants would like to have group photo, group photo is taken		

3.5.3 POST TRAINING PROCESS CHECKLIST

Activities	Done	Not done
Prepare training reports and document with complementing photos Plan follow-up of training		
If participants are interested and the need arise, refresher training can be organized		
If the need arises, participants could be mailed IEC materials periodically		
Evaluation of training planned and executed		
Followup of the training planned and executed		

CHAPTER IV

AN INDEPTH INTO THE TRAINING

Because of the complex nature and importance of methodology of learning, the training method is differently dealt in a separate chapter. The chapter consists of the following frame,

4.1 Trainer and trainee introductory sessions (ice breaking sessions)

4.2 Introducing training

4.3 Explaining the training methods

4.4 Training schedule

4.1 Trainer and trainee introductory sessions: (ice-breaking sessions)

TRAINING OBJECTIVES

To eliminate the fear and inhibitions (shyness) of participants and to make the environment friendly for the participants.

To make a congenial environment for participants to participate completely in the training program.

Training should result in a two-way communication. The trainer should know the trainees by name, environment and background.

Many games are explained, the trainer could select any one.

GAME I : Picture Matching Game

Finding the other part of the picture which is torn into two pieces

Time : 30 minutes

Materials needed : One picture torn into two pieces for every pair (eg. 5 pictures for 10 participants)

Methods:

Fold the torn parts of the pictures and distribute them at random. Each participant has to find the other half of his/her picture which is with some other participant. After finding the person who has the other half of the picture, pair together and then introduce each other to the group.

GAME II STAR GAME

Time : 40 minutes

Materials needed : Sample format for the game

Name of the Trainee :

Section 1.

Section 2.

	Marks					How many stars awarded
a)	1	2	3	4	5	
b)	1	2	3	4	5	
c)	1	2	3	4	5	
d)	1	2	3	4	5	
e)	1	2	3	4	5	

Method:

Each trainee is provided with one sample format of the game printed above. This format consists of two sections. The trainee writes his/her name and answers all the five questions printed on the tails of the star. Below the question each trainee writes very briefly the answers of each question. This could take 10 minutes.

Next step is that each trainee takes with her/him the completed star format, meets atleast five co-trainees and explains each answer. The co-trainee after listening to the first person, gives marks by encircling the appropriate mark in section two grading him between 1 to 5. The interaction time with one person is 5 minutes and therefore this activity takes 25 minutes. The 1st trainee looks at the marks got from each of his/her co-trainees (5 persons). The maximum score of 5 corresponds to one star which means that if a participant gets a score of 5 from all 5 of his peers, he will be awarded a 5 star by the trainer at the end of the session. The 1st trainee has to look into how many fives he has got and calculate accordingly. This exercise familiarizes one another.

GAME III : BALL GAME

Time : 30 minutes

Materials needed : A plastic ball

Methods:

The trainees stand in a circle and a plastic ball is given to one trainee who throws it after calling out his name and background and the individual who catches it has to repeat the same and throw back to another person. This can be continued as long as possible; ground rule of this game is that trainees should not throw the ball above the shoulder level.

4.2 Introducing training:

Introduction of the training is done after enumerating the needs assessment findings and stating the objectives of the project. From this, the broad objective of the training is defined in a collaborative manner. After this the frame of the training, learning objective, time schedule, person who is going to deal with the subject, what method and materials are going to be used are explained. Later training measurement methods are explained.

4.3 Explaining the training methods:

4.3.1 SMALL GROUP WORK

3 to 5 members are ideally grouped together and specific topics given for discussion to share their previous knowledge and experience. Usually the group selects a group reporter who takes note of the proceedings. A facilitator is also chosen who facilitates and maintains the group dynamics. The time limit is 20-30 minutes. At the end, the reporter reports the findings to the whole group.

Advantages:

- Maximizes participation
- The method is based on sharing information and experience
- Develops leadership qualities, facilitating skills, reporting and boldly expressing views / skills in the participants
- Develops a shared pedagogy
- Develops fundamental values and processes
- Breaks down hierarchical teaching structure
- Group members feel that they are equal to their partners
- Stressing co-operative support in solving problems

Disadvantages:

- Time consuming exercise
- Correlating findings of every small group and reinforcing the learning to the whole group is challenging
- Careful group dynamic control is necessary

4.3.2 LECTURE

The Trainer carefully prepares as per the learning objectives the lessons and explains to the trainees through appropriate educational materials and equipment.

Advantages:

- Easy to plan and execute, traditionally used method, trainees accept this technique easily
- Trainers are more comfortable as they dominate the show.
- Lectures if made highly interactive are a useful way of education.
- The trainer can adapt the level of difficulty of the lecture according to the ability levels of the homogenous group.

Disadvantages:

- If there is no interaction, this becomes a one way communication and hence the educational process is incomplete

4.3.3 DEMONSTRATION

In simple words, a demonstration is showing the trainees how to do something by modeling the action. A demonstration should always be followed by a repeat demonstration by the trainees. By this method usually not only knowledge level increases but also skills are effectively passed on.

4.3.4 BRAINSTORMING

Participants are made to sit in a circle and the facilitator also sits with them. A problem or a topic is given to the trainees and everybody is asked to give one relevant solution or answer from their present knowledge / experience, but very quickly. Thus, every participant gets an opportunity to answer quickly about what they have got in the mind. The majority of the correct answers are taken as solution. Brainstorming could go through many rounds.

4.3.5 FISH BOWL TECHNIQUE

The trainees are divided into two groups of 6-7 members each. One group sits in the inner ring and the other group sits/stands in the outer ring. The inner ring picks up the issue and conducts a group discussion for 15 minutes following the techniques of the group work. The outer ring members observe, listen and learn from the inner ring's deliberations. Now the groups change their role, the outer ring becomes the inner and the inner becomes the outer; inner group deliberates on the same issues with the experience gained from the other group for 15 minutes whereas the present outer group learn from inner group. Thus both the groups learn from each other.

4.3.6 ASKING QUESTIONS AND FACILITATING ANSWERS RANDOMLY

This is done by using structured questionnaire or asked in general. Care is taken to avoid specifically asking one person in a threatening way. Here the only disadvantage is basically trainees who usually openup quickly will dominate the scene entirely and the quiet ones tend to shy away.

4.3.7 OPINION POLLING

Topic or problem is given to the whole group of trainees and answers are welcomed from the trainees. Those who volunteer can answer. When answers are given, all the answers are noted on the black board / white board. The opinion expressed by the majority is accepted. Here the disadvantage is some trainees dominate the show.

4.3.8 ROLE PLAY

Here the trainees enact the given situation. The observing trainees learn from the situation.

4.3.9 CASE STUDY

Here the trainer is facilitated to narrate a life story from an experience related to the specific topic of learning. Once the story is narrated, there is a group discussion on how to manipulate the situation towards behavioural change and so on. Here the names of people and places are to be changed during narration.

4.4 Training Time Schedule:

There are three popular methods of Training PEs as far as time schedule is concerned,

- Cumulative learning over a period of time
- Gun shot learning
- A combination of the above two methods

CUMULATIVE LEARNING

Here the trainer trains the trainees over a period of time (usually 6 months); where the subjects are introduced in a phased manner; usually a session per week / fortnight.

Advantages:

- Small doses of knowledge dissemination lead to no confusion
- There is no pressure of time
- PEs could take off time from their work weekly once and could be relaxed
- Trainer also has advantages like time availability

Disadvantages:

- Continuity of the learning will be interrupted
- PEs may find it difficult to come frequently for training
- Activation period of the peer circuit will be delayed if the training is prolonged

GUN SHOT TRAINING

Here the training is organized at one time, lasting from morning to evening in a day and four to five days total duration. Later there will be a followup of the training worked out.

Advantages:

- The continuity of the learning could be assured
- PEs could develop better aptitude for the training as they realize that they are in a controlled situation over a period of time
- PEs could designate their time to the training at one slot, taking off from their numerous other routines
- PEs will interact with other trainees better, develop a good network and there will be more opportunities to share experiences and learn from each other
- The relationship between the trainer and trainees also will build up over a period of constant interaction
- For trainer also organizing the training at one stretch has lots of advantages
- During the followup, reinforcement of only essential knowledge and skill could be provided towards sustainable behaviour change.

Disadvantages:

- There is a possibility of developing confusion with trainees because of numerous type of information flowing
- Attendance of trainees for all the days is difficult
- Trainees may develop mental fatigue because of the intensive nature of the training

CHAPTER V

THE TRAINING SCHEDULE AND THE TOPICS

This chapter, as a ready reckoner, the topics to be covered, training methods and time schedule is presented in the matrix form. The material provided is exhaustive and is to be selected for individual training situation and a detailed research is necessary before formulating the training. Total duration time planned is presented in the matrix, the trainer to decide on to have a gun shot training or cumulative training.

Training schedule matrix

Major components	Time (minutes)
Ice breaking	60 (1 hour)
Preventive training	950 (15 hours 50 minutes)
VCTC and Care & Support	300 (5 hours)

This chapter is presented in the following frame:-

5.1 Basics - Sexually Transmitted Infections

5.2 Basics - HIV/AIDS

5.3 Condom promotion

5.4 Condom negotiation methods for penetrative sex

5.5 Negotiating for non penetrative sex

5.6 Behavioural change communication

5.7 Counseling

5.8 Role of PEs and the incentives

5.9 Voluntary Counseling and Testing Centre

5.10 Care and Support PLWHA

5.11 Final Evaluation of the total Training program

5.1 Basics- Sexually Transmitted Infections:

Time : 4 hours

Materials: Flash cards about STIs, Slide projector, STI slides, O.H.P

Learning objective: After the session, PEs will be capacitated to recognize STI, know where to treat STI and how to prevent STI.

BASICS: SEXUALLY TRANSMITTED INFECTIONS TRAINING MATRIX

S.N	Learning topics	Learning method	Time (Minutes)
1.	What is health?	Lecture	10
2.	What is Disease?	Lecture	10
3.	What is communicable disease & STI	Lecture and demo✱	10
4.	Participant sharing their experience & knowledge about STI	Small group discussion	20
5.	Major and minor symptoms of STI in man and woman	Lecture, game	30
6.	STI treatment	Lecture	15
7.	Concepts of relapse and re-infection	Lecture	10
8.	After effects of STI if not treated	Lecture	15
9.	Women and STI - Anatomical reason - Social reason - Economic reason	Lecture and Small group work	10 20
10.	Myths & misconception about STI	Opinion polling	30
11.	High risk behavior groups and STI	Brain storming fast tracking	20
12.	Methods of preventing STI	Lecture	10
13.	Clarifications	Questioning	15
14.	Measuring the effectiveness of learning, sessional evaluation	Questioning or questionnaire	15

✱ Two simple plastic toys, one male and other female are selected. In the male organ area, paste some "kumkum". This could be explained as male suffering from STI. Demonstrate the 2 toys hugging each other and then show the female toy to the trainees. They will realize that the kumkum is now on the female toy also (STI infection). This could explain how infectious diseases spread from one person to another by physical contact and STI by sexual encounters. The same game to be continued for STI treatment as well as for condom sections appropriately which will be described later.

5.2 Basics- HIV/AIDS:

Time: 2 hours

Materials: OHP, Slide projector, Marker pen, and Papers

Learning objective: After the training session, trainee will develop capacity to realize the link between STI and HIV/AIDS, how HIV/AIDS spreads and how does not spreads and how condom prevent HIV infection.

BASICS: HIV/AIDS TRAINING MATRIX

S.No	Learning Activities	Learning Method	Time (minutes)
1.	What is HIV, What is AIDS, How HIV progresses in the body, what happens to the body because of HIV virus	Lecture	15
2.	Why sexual route is the major route for HIV spread	group work	15
3.	High risk behavior and vulnerable group to HIV/AIDS infection	Group discussion	15
4.	How does and does HIV not spread	Flash Cards	20
5.	Symptoms of HIV/AIDS in later stages	Lecture	10
6.	Link and differences between HIV/AIDS and STIs	Game	15
7.	Methods of preventing HIV/AIDS spread	Lecture	15
8.	Sessional evaluation	Questioning / questionnaire	15

5.3 Condom Promotion:

Time: 3 hours

Materials required: Flash card showing correct condom usage, penis model, varieties of condom

Learning Objective: At the end of the session, the trainees will understand how to use condom correctly during every sexual encounter.

CONDOM PROMOTION TRAINING MATRIX

S.N	Learning Activities	Learning Method	Time (Minutes)
1.	What is condom and its three uses	Display and lecture	10
2.	Availability of condom, quality and varieties of condoms	Lecture, opinion polling, display	20
3.	Myths and misconceptions in using condoms	Opinion polling	20
4.	Condom storage at home and buying without hesitation	Role play technique and small group work	30
5.	Reasons why condom fails	Small Group discussion ✶ and lecture	30
6.	Correct Consistent use of condoms	Demonstration ✶✶ and repeat demo	60
7.	Sessional evaluation	Questioning	10

✶ The trainer could supplement the following reason for condom failure, if the points are not coming up in the group work.

- new comers to the commercial sex circuit takes time and are not serious about condoms
- non availability of free as well as commercial condoms
- many players (projects) working with same target groups, the messages get distorted
- poor condom negotiation skills
- message fatigue with condom usage messages
- poverty of sex workers, who loose condom to money
- "husband" sentiments and "husband" not knowing the working of wife as sex worker
- sentiments with regular partners
- myths and misconceptions about condoms
- exploitation of HIV/AIDS scenario by some health care providers with the message that AIDS is curable / preventable with drugs

✶✶ The same demo in page 53 is repeated with two dolls. This time, a thin piece of rubber is pasted over the kumkum and then make the doll hug each other. Now the trainees will realize that the kumkum is not passed on to the other doll because of the rubber placed in between. This is a simple of showing how the condom protects against the spread of STI, HIV/AIDS infection.

5.4 Condom negotiation methods for penetrative sex:
(This session is a special session for FSW PEs, TG PEs and MSM PEs)

Time: 2 hours

Material required: Penis model, condom for demo

Learning objective: By the end of the session the trainees will develop methods of convincing the client / husband / live in partners to use condom for penetrative sex.

MATRIX OF CONDOM NEGOTIATION METHODS FOR PENETRATIVE SEX

S.No.	earning activities	Methods	Time (minutes)
1.	Listing condom negotiation skills	1. Small Group discussion 2. Additional information by Trainer ✸	45 minutes
2.	Skill development exercises	Demo for condom fixing by hand and by oral method	45 minutes
3.	Evaluation	Repeat demo	30 minutes

✸ Note:
The following are some of the condom negotiation skills learned, if this does not come up in discussion, the trainer could supplement the information,

- the recipient himself / herself by his/her hand fixing the condom on the client, instead of client himself wearing the condom,
- prolonging foreplay and thus making the client accept condom,
- requesting the client politely to accept condom telling personal excuses like period time, pregnancy scare or pretending to be in deep love with the client and wants to have penetrative sex for a longer time and for these reasons requesting him to use condom,
- negotiating for oral sex with condom, if the client wants anal / vaginal sex without condom, (less risk than the other two means),
- volunteering to fix the condom on the penis by oral method,
- offering an alcoholic drink in order to persuade the client to use condom,
- if the client / partner is already drunk, not to negotiate but simply to fix the condom before encounter.

Special Note:

- Not to negotiate by telling the client about STI or HIV / AIDS before sexual act which will decrease her/his demand in the market, but to talk about diseases after the sexual act.

- Not to drink alcoholic drinks before sexual act as this act will tamper the process of negotiation, but if wants to please the client, to drink after the act with him.

- "No condom No sex" negotiation usually never happens and the slogan to be "more enjoyable sex with condom" and the sex trade PEs could promote condom by using this slogan.

- For sex workers, talking about diseases and negotiating for condom to be attempted with people who seek free sex like police force, brokers, etc.

5.5 Condom negotiation methods for non penetrative sex:

Time : 1 hour

Material required: Flash card showing different types of non penetrative sexual acts

Learning objective: At the end of this session, participants will list out the different types of negotiations for non-penetrative sex and practice it.

TRAINING MATRIX OF CONDOM NEGOTIATING FOR NON-PENETRATIVE SEX

S.No.	Learning Activities	Methods	Time (minutes)
1.	Listing non penetrative safe sexual practices	1. Small group discussion 2. Game ✸ 3. Trainer complementing	40 minutes
2.	Evaluation	Questioning	20 minutes

✸ Game: Mixing up the picture cards of both penetrative sexual methods with condoms and other negotiation acts without penetrative sexual practices; the trainees in a group are asked to pickup only pictures cards containing non-penetrative sexual practices.

Note: Some of the non penetrative sexual acts learned are,

- increasing the time of foreplay enormously and diverting the client in it, so that he may not ask for penetrative act or settle for a self masturbation / mutual masturbation
- Tempting the client for masturbation by massaging the glands penis for a long time
- Providing a tight by penis holding local toy, facilitating the penis into it and helping him to ejaculate semen by performing on this equipment
- Applying a tight ribbon over penis and masturbating
- Thigh sex
- Knee joint sex
- Elbow joint sex
- Arm pit joint sex
- Inserting penis in between the breasts which are held tightly against the penis by the facilitator and thus making ejaculation possible
- Making the client drink alcoholic drinks, when he is high, masturbating by facilitator
- Allowing cunnilingus with condom and satisfying the client immediate afterwards with a masturbation
- With IVD users, when they are closed, coaxing for masturbation.

5.6 Behavioural change communication:

Time: 1 hr and 20 minutes

Methods:

Learning objectives : The trainees will realize at the end of the session that themselves and their peers have to achieve the behavioural changes vide correct, consistent condom usage in every penetrative sexual encounter; if STI symptoms present, taking full complete treatment; FSW, MSM, TG members to undergo RMC and if there is any block in changing over to these behavioural changes to use counseling services; they will also realize that to achieve this, they have to use communication techniques.

BEHAVIOURAL CHANGE COMMUNICATION TRAINING MATRIX

S.No.	Learning Activities	Methods	Time
1.	Basics about effective communication	Role play	20 minutes
2.	Basics about one to one Interaction	Role play	15 minutes
3.	Basics about one to small group interaction	Role play	15 minutes
4.	Use of IEC material	Demo and repeat demos	15 minutes
5.	Evaluation	Repeat Demos	15 minutes

5.7 Counseling:

Time : 1 hour

Learning objective: By the end of the session trainees will understand what is counseling, the importance of counseling in PE's working and for what purposes refer their peers to counseling centers.

S.No.	Learning activities	Methods	Time
1.	Introducing counseling and its importance in prevention and control work	Lecture	15 minutes
2.	When to refer the peers to counseling services	Lecture	15 minutes
3.	Evaluation of the session	Roleplay	30 minutes

5.8 Role of PEs, the incentives and records and reporting:

Time: 1 hour and 30 minutes

Learning objective: At the end of the session the PEs will list out their future jobs and the incentives they will get for their work.

S. No.	Learning Activities	Learning methods	Time
1.	Role of PEs in STI, HIV/AIDS prevention and control program	Brain storming	30 minutes
2.	Incentives	Lecture	20 minutes
3.	Records and reporting	Lecture	30 minutes
4.	Evaluation	Question and answer	10 minutes

5.9 Voluntary counseling and Testing Centre (VCTC):

Time : 1 hour

Materials : OHP

Learning objective: After the session, PEs will realize that all the vulnerable community members have to know their HIV status and attend counseling before and after testing.

VCTC TRAINING MATRIX

S.No.	Learning Activities	Learning methods	Time
1.	What is VCTC	Lecture	10 minutes
2.	Who should attend VCTC	Lecture	10 minutes
3.	Pre-test counseling	Lecture	15 minutes
4.	Post-test counseling	Lecture	15 minutes
5.	Sessional evaluation	Questioning	10 minutes

5.10 Care and Support People Living With HIV/AIDS (PLWHA):

Time : 4 hours

Material : Charts, Marker pens

Learning objective: After the session, the PEs will understand and repeat what is Care and Support and in what possible ways he/she could provide care and support.

CARE AND SUPPORT TRAINING MATRIX

S.No	Learning Activities	Learning methods	Time
1.	What is Care and Support	Lecture	10 minutes
2.	What care and support could be provided to PLWHA OI Nutrition Spiritual support Sexual health Continuum of care	Lecture and group work	110 minutes
3.	What care and support could be provided to family Everybody is at risk concept Caring at home Counseling services	Lecture and group work	60 minutes
4.	What care and support could be provided to community Stigma and care of dead	Lecture and group work	60 minutes

5.11 Final Evaluation of the total Training program:

I. Learning experience sharing by trainees: -

Randomly selected trainees shall share the experience of the training under the following heading,

- venue
- timings
- food and stay
- trainer's communication skill, appropriate use of audio visuals
- training content
- training methodology
- very clear about _____
- not still clear about _____
- what sort of followup needed?

II. Questioning:

The following are sample questions and answers, the questions could be randomly selected to assess knowledge gained or systematically selected.

Expansion for STI (Sexually Transmitted Infection)
Expansion for HIV (Human immuno Deficiency virus)
Expansion for AIDS (Acquired immuno Deficiency Syndrome)

1 Mention two differences between STI and HIV

i. STI has symptoms, HIV does not to have symptoms in the initial stages
ii. STI is completely curable, HIV is only manageable

2. How does HIV spreads mostly?
Unprotected sex

3. Which is the risky sexual behavior?
i. If not married having premarital sex
ii. Having many sexual partner
iii. Penetrative sex without condom in sex other than wife / husband

4. What are the safe sex practices
i. Abstaining from sex till marriage
ii. Being faithful to one partner
iii. Using condom in risky penetrative sexual acts

5. STI for both male and female shows external symptoms, True / False
True

6. Which age group is mostly affected by HIV/AIDS?
14-45 age group

7. Is HIV disease a STI?
In most cases HIV is sexually transmitted, from a man to a woman or from a woman to a man or from a man to another man. However HIV can spread through transfusion of HIV containing blood or by sharing of infected needles used for IVDUs or from a mother to her baby.

8. Does one or more attacks of STI lead to HVI disease?
No. STIs do not lead to or change to HIV disease. But STIs increase the risk of a person to acquire HIV. Ulcer or discharge of STI makes it easier for HIV to enter the body.

9. Can one get HIV disease without any STI?
Yes

10. What will happen if STIs are not treated in men and women?
There will be complications like sterility, abortion(s), still birth, disease of the new born, uterus cancers, block in passing urine in men, for that matter heart and brain also could be affected.

11. Can one have more than one STI at a time?
Yes.

12. Will the blood test (VDRL) detect all STIs?
No. It can detect only one STI namely Syphilis out of nearly 30 diseases.

13. Will Blood VDRL Test be positive (reactive) if a person has HIV?
No, unless when the HIV positive person has syphilis also.

14. Does Pencillin injection cure all STIs?
No. one type of Pencillin injection is used to cure only one STI namely Syphilis and not other STIs.

15. Is hospitalization necessary for STI patients?
No. STI patients could be treated as out patients. Hospitalisation may be needed for those with late, severe complications.

16. Can one prevent STI by washing genitals with one's own urine or soap and water or by passing urine soon after sex?
No, it is a myth.

17. Can STI be prevented by applying antiseptic ointments or by taking antibiotic capsules or tablets or penicillin injection soon after sex?
No.

18. Can the same methods prevent STI (antiseptic application, antibiotic, penicillin injection) if taken just before sex?
No.

19. Are all STIs treated by injections?
No, effective medicines are available as tablets and capsules.

20. Does sex with a menstruating woman cause STI?
No, unless she has STI

21 Is STI caused by using a common toilet?
No

22. How does HIV act in our body
It destroys the WBC which inturn lowers the immunity of the individual

23. Can STI completely curable
Yes, possible with complete treatment and partner treatment

24. Can you tell the symptoms for STIs?
Genital ulcer, pus like discharge in genitals, Inguinal adentities, burning micturation, lower abdominal pain (women), scrotal pain (men)

25. What are the benefits of using condom?
i. Avoids pregnancy
ii. Protects from STI, HIV/AIDS infection
iii. Increases pleasure

26. What varieties of condoms are available?
Lubricated, striped, dotted, flavoured, coloured, spermicidal

27. Condoms are available in what colors?
Pink, green, black, rose, yellow

28. What flavours of condoms are available for oral sex?
Pine apple, strawberry, mint, banana, chocolate, vannila

29. Give the names of condoms available in the market?
K.S. Moods, Kohinoor, etc

30. Can you say the prices of common condoms available in the stores?
Nirodh deluxe, price Rs.2 for 3 (cheapest)

31. What is the most important step in condom wearing?
Letting out the air from the pouch before fixing it on penis. This protects against bursting and tearing of condom

32. What is the link between STI and HIV/AIDS?
STI facilitates HIV infection

33. What is HIV, HIV + and AIDS?
HIV is the virus, HIV+ is the initial status of AIDS when the blood tests positive and AIDS is the disease when it progresses

34. What is VCTC?
It is a place where counseling and HIV testing available for just Rs.10/-

CHAPTER VI

THE KEY MESSAGES FOR THE PEs IN A NUTSHELL

Peer Educator should remember the following **15-point** program all the time and should make the peers to be thorough with the program. A practical method of remembering the program is by going through this small chapter daily.

In a nutshell key messages for all PEs are,

1. STI and HIV/AIDS are communicable diseases contracted and passed on by penetrative sexual encounters
2. STI facilitates HIV/AIDS infection and so it must be treated
3. STIs are many diseases but present as pus like discharge (men and women), ulcer/ blisters in the reproductive organs (men and women), bilateral inguinal adenities (men & women), burning micturation (men and women), lower abdominal pain (women), scrotal pain and mild swelling (men)
4. STIs are completely curable with full, complete and partner treatment
5. STI is difficult to be diagnosed in women, routine medical checkup is important for members of commercial sex circuit
6. HIV/AIDS is a manageable disease but not curable, but a lot of healers exploit the uninformed by telling lies and by false advertising
7. STI and HIV/AIDS are prevented by using condoms correctly and consistently at every penetrative sexual encounter
8. For oral sex, flavoured condoms are available
9. For anal sex use single condom only with KY jelly
10. Important step of correctly wearing the condom is expelling the air in the pouch before and while fixing the condom onto the penis
11. There are more than 100 varieties of condoms available in India which could be bought from pharmacies and other shops
12. There are lot of myths and misconceptions about sex and sexuality, STI and HIV/AIDS and condoms which are all false statements
13. Care and Support is possible for PLWHA
14. Counseling centers help to solve problems and should be utilized efficiently
15. PE should realize that all the vulnerable population should be counseled to test their blood for their status and after testing to be counseled again

ABBREVIATIONS

AIDS	ACQUIRED IMMUNO DEFICIENCY SYNDROME
APAC	AIDS PREVENTION AND CONTROL
BC	BEHAVIOURAL CHANGE
CCOORR	CHRISTIAN COUNCIL FOR RURAL DEVELOPMENT & RESEARCH
FGD	FOCUS GROUP DISCUSSION
FSW	FEMALE SEX WORKER
HAI	HEALTH AFFILIATES INDIA
HIV	HUMAN IMMUNO DEFICIENCY SYNDROME
HRB	HIGH RISK BEHAVIOUR
IDI	IN-DEPTH INTERVIEW
IEC	INFORMATION EDUCATION COMMUNICATION
IGD	INFORMATION GATHERING DISSEMINATION
IVDU	INTRA VENOUS DRUG USERS
MSM	MEN HAVING SEX WITH MEN
NACO	NATIONAL AIDS CONTROL ORGANISATION OF GOVT.OF INDIA
OHP	OVER HEAD PROJECTOR
OI	OPPORTUNISTIC INFECTION
PE	PEER EDUCATOR
PES	PEER EDUCATION SYSTEM
PLWHA	PEOPLE LIVING WITH HIV / AIDS
QBCC	QUALITY BEHAVIOURAL CHANGE COMMUNICATION
RMC	ROUTINE MEDICAL CHECKUP
STI	SEXUALLY TRANSMITTED INFECTION
TG	TRANS GENDER
TNA	TRAINING NEEDS ASSESSMENT
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
VCTC	VOLUNTARY COUNSELING AND TESTING CENTRE
VDRL	VENEREAL DISEASE RESEARCH LABORATORY
VE	VOLUNTEER EDUCATOR
WBC	WHITE BLOOD CORPUSCLES

Name of the book	:	**Peer Education System in HIV/AIDS programs – a unique experience**
Author	:	**Dr. Ravi Raj William, M.B.B.S., M.P.H. (Belgium)**
Published by	:	**Health Affiliates India (HAI) - CCOORR**
No.of copies	:	**300**
Year of publication	:	**2003**

(Education material meant for those who are engaged in HIV/AIDS programs)